OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff: (Pharmacy) 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: Xyrem® (sodium oxybate)

**DRUG INFORMATION:** Complete information below or authorization will be delayed if incomplete.

<table>
<thead>
<tr>
<th>Drug Form/Strength:</th>
<th>Length of Therapy:</th>
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<tr>
<th>Dosing Schedule:</th>
<th>Diagnosis:</th>
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<th>ICD Code, if applicable:</th>
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- To guard against diversion and misuse, the drug’s distribution is limited and prescribers **must** adhere to a risk management protocol, the Xyrem® REMS Program.

**CLINICAL CRITERIA:** Check below **ALL** that apply. **ALL** criteria must be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

Initial Authorization Approval – 12 months.

- Patient is at least 7 years old
- Patient is **NOT** receiving treatment with sedative hypnotics, other CNS depressants (verified by paid pharmacy claims)
- Patient is **NOT** using alcohol
- Patient does **NOT** have a history of drug abuse

**AND**

- Patient has a diagnosis of narcolepsy with cataplexy (MSLT confirming diagnosis of narcolepsy and chart notes documenting cataplexy symptoms must be submitted. If polysomnography required, please submit with MSLT).

**OR**

- Patient has a diagnosis of excessive daytime sleepiness associated with narcolepsy. **AND** has failed a 30-day trial of modafinil or armodafinil. (MSLT confirming diagnosis of narcolepsy and chart notes documenting cataplexy symptoms must be submitted. If polysomnography required, please submit with MSLT)

(Continued on next page)
Member’s age <18 years old must be dosed as follows (doses above maximum recommended dose will not be approved):

- 20kg: consider lower initial dosage, lower maximum weekly dosage, and lower total maximum nightly dosage.
- 20 to <30kg: maximum dose: 3 grams/dose; 6 grams per night
- 30 to <45kg: maximum dose: 3.75 grams/dose; 7.5 grams per night
- ≥45kg: maximum dose: 4.5 grams/dose; 9 grams per night

Member’s current weight must be noted if <18 years old: ________________

**Use of samples to initiate therapy does not meet step edit/preauthorization criteria.**

*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

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Reauthorization of Therapy: Yearly reauthorization is required for continuation of therapy.

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Patient Name: ____________________________________________________________

Member Optima #: _____________________________________ Date of Birth: __________

Prescriber Name: __________________________________________________________________________________________

Prescriber Signature: ___________________________ Date: ________________

Office Contact Name: __________________________________________________________________________________________

Phone Number: ___________________________ Fax Number: ___________________________

DEA OR NPI #: ___________________________

*Approved by Pharmacy and Therapeutics Committee: 10/18/2012